Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PASO DEL NORTE SURGERY CENTER
125 SEST CASTELLANO
EL PASO TX 79912-6108

Respondent Name

INDEMNITY INSURANCE CO OF NORTH AMERICA

Carrier's Austin Representative

Box Number 15

MFDR Date Received

FEBRUARY 5, 2013

MFDR Tracking Number

M4-13-1412-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please see attached claim form with ref provider # previously claims have been paid before. Please process."

Amount in Dispute: $7,109.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 30, 2012	ASC Services for CPT Code 23700-LT-SG	$6,038.00	$1,357.07
	ASC Services for CPT Code 20610-59	$1,071.00	$0.00
TOTAL		$7,109.00	$1,357.07

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, effective May 31, 2012, sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits

- 52-The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.

Issues

1. Did the respondent support denial of reimbursement for disputed services?
2. Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason code "52."

   The requestor is a licensed Ambulatory Surgical Care Center in Texas.

   On August 29, 2012, the respondent's representative, GENEX, gave preauthorization approval for the disputed services to be rendered at Paso Del Norte Surgery Center.

   The Division finds that the requestor has not supported the denial of the disputed services based upon reason code "52."

2. 28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   CPT code 23700 is defined as "Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)."

   The August 30, 2012 operative report notes that the claimant underwent "Shoulder manipulation and injection, left shoulder under general anesthesia."

   The Division finds that the documentation supports billed service; therefore, reimbursement is recommended per Division rules and guidelines.

   28 Texas Administrative Code §134.402(f)(1)(A) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent."

   According to Addendum AA, CPT code 23700 is a non-device intensive procedure.

   The City Wage Index for El Paso, Texas in El Paso County is 0.8515.

   The Medicare fully implemented ASC reimbursement for code 23700 CY 2012 is $623.81.

   To determine the geographically adjusted Medicare ASC reimbursement for code 23700:

   The Medicare fully implemented ASC reimbursement rate of $623.81 is divided by 2 = $311.90

   This number multiplied by the City Wage Index is $311.90 X 0.8515 = $265.58.

   Add these two together $311.90 + $265.58 = $577.48.

   To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235%: $577.48 X 235% = $1,357.07.

   The respondent paid $0.00. The requestor is due the difference between the MAR and amount paid = $1,357.07.

3. CPT code 20610 is defined as "Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)."

   Per NCCI edits CPT code 20610 is a component of CPT code 23700; however, a modifier is allowed when appropriate. The requestor utilized modifier "59" to differentiate it as a separate service.

   Modifier 59's descriptor is "**Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-Evaluation and Management

(E/M) services performed on the same day. Modifier 59 is used to identify procedures or services other than E/M services that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available and the use of modifier 59 best explains the circumstances should modifier 59 be used."

The August 30, 2012 Operative report does not support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual; therefore, the requestor did not support the use of modifier 59. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,357.07.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,357.07 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		08/15/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.